STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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1. **Inpatient hospital services other than those provided in an institution for mental diseases.**

   Provided: ☐ No limitations ☒ With limitations*

2. a. **Outpatient hospital services.**

   Provided: ☐ No limitations ☒ With limitations*

   b. **Rural health clinic services and other ambulatory services furnished by a rural health clinic.**

   ☒ Provided: ☐ No limitations ☒ With limitations*

   ☐ Not Provided.

   c. **Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA Pub.45-4).**

   ☒ Provided: ☐ No limitations ☒ With limitations*

3. **Other laboratory and x-ray services.**

   Provided: ☒ No limitations ☐ With limitations*

* Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. **Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.**

Provided: ☒ No limitations ☐ With limitations*

b. **Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.***

c. **Family planning services and supplies for individuals of child-bearing age.**

Provided: ☐ No limitations ☒ With limitations*

5. a. **Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.**

Provided: ☐ No limitations ☒ With limitations*

b. **Medical and surgical services furnished by a dentist (in accordance with §1905(a)(5)(B) of the Act).**

Provided: ☐ No limitations ☒ With limitations*

6. **Medical care on any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.**

a. **Podiatrists' services.**

Provided: ☐ No limitations ☒ With limitations*

☐ Not provided

* Description provided on attachment.

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b. Optometrists' services.

☒ Provided: ☒ With limitations*

☐ Not provided ☐ No limitations

c. Chiropractors' services.

☐ Provided: ☐ With limitations*

☒ Not provided ☐ No limitations

d. Other Practitioners' services.

☒ Provided: ☐ Not provided
(Identified on attached sheet with description of limitations*)

7. Home health services.

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment.

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d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☒ With limitations*

☐ Not provided ☐ No limitations

8. Private duty nursing services.

☐ Provided: ☐ With limitations*

☒ Not provided ☐ No limitations

* Description provided on attachment.

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9. **Clinic services.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

10. **Dental services.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

11. **Physical therapy and related services.**

a. **Physical Therapy**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

b. **Occupational Therapy.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

c. **Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

*Description provided on attachment.

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12. **Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. (See Page 13 for Prescribed Drugs and Eyeglasses.)**

a. **Prescribed drugs.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

b. **Dentures.**

☐ Provided: ☐ With Limitations*

☒ Not provided ☐ No Limitations

c. **Prosthetic devices.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

d. **Eyeglasses.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

13. **Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan. (See Page 14 for diagnostic and other services.)**

a. **Diagnostic services.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

b. **Screening services.**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

* Description provided on attached sheet. See Supplement 1 to Attachments 3.1-A and 3.1-B.

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13. Other diagnostic, screening, preventive, rehabilitative services (Continued)

c. Preventive services.

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

d. Rehabilitative services. (See Page 9, Home Health Services)

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

14. Services for individuals age 65 or over in institutions for mental diseases. (See Page 15 for IMD services for persons over 65.)

a. Inpatient hospital services.

☒ Provided: ☐ With Limitations*

☐ Not provided ☒ No Limitations

b. Skilled nursing facility services.

☒ Provided: ☐ With Limitations*

☐ Not provided ☒ No Limitations

c. Intermediate care facility.

☒ Provided: ☐ With Limitations*

☐ Not provided ☒ No Limitations

* Description provided on attached sheet. See Supplement 1 to Attachments 3.1-A and 3.1-B.

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15. a. **Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31)(A) of the Act, to be in need of such care.**

☒ Provided: ☐ With Limitations*

☐ Not provided ☐ No Limitations

b. **Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.**

☒ Provided: ☐ With Limitations*

☐ Not provided ☒ No Limitations

16. **Inpatient psychiatric facility services for individuals under 22 years of age.**

☐ Provided: ☐ With Limitations*

☒ Not provided ☐ No Limitations

17. **Nurse-midwife services**

☒ Provided: ☒ With Limitations*

☐ Not provided ☐ No Limitations

18. **Hospice care (in accordance with §1905(o) of the Act).**

☒ Provided: ☐ With Limitations*

☐ Not provided ☒ No Limitations

* Description provided on attachment.

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19. **Case management and Tuberculosis related services**

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with §1905(a)(19) or §1915(g) of the Act).

☒ Provided: ☐ Not Provided ☒ With limitations*

b. Special tuberculosis (TB) related services under §1902(z)(2)(F) of the Act.

☐ Provided: ☒ Not Provided ☐ With limitations*

20. **Extended services to pregnant women:**

a. **Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.**

☒ Provided+: ☒ Additional Coverage++ See Supplement 3.

b. **Services for any other medical conditions that may complicate pregnancy.**

☒ Provided+: ☐ Additional Coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in the this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

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21. **Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with §1920 of the Act).**

☐ Provided: ☐ With limitations*

☒ Not provided ☐ No limitations

22. **Respiratory care services (in accordance with §1902(e)(9)(A) through (C) of the Act).**

☐ Provided: ☐ With limitations*

☒ Not provided ☐ No limitations

23. **Pediatric or family nurse practitioners' services.**

☒ Provided: ☐ Not Provided ☒ With limitations*

* Description provided on attachment.